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Notice of Independent Review Decision

DATE OF REVIEW: August 3, 2011 **Amended: 8/4/11**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

VAT, ENG, ImPACT, visual evoked potential, otoacoustic emission, platform posturography and visagraph including 92546, 92545, 96111, 95930, 92588, 92548

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Fellow American Academy of Ophthalmology

Certified by the American Osteopathic Board of Ophthalmology American Society of Cataract and Refractive Surgery

Member American College of Eye Surgeons – Houston Ophthalmological Society

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient fell at work on xx/xx/xx. She slipped on a paper towel hitting her head after falling. She reported visual blurring, headaches and dizziness.

Following the injury, the patient complained of neck and back pain, headaches, poor concentration and processing, as well as difficulty with peripheral vision. She could not go back to work primarily due to her difficulty with cognitive reasoning.

The patient underwent neuro-optometric evaluation by O.D., in July 2010, for ongoing headaches, blurred vision and balance problems. Her visual examination showed deficits in visual tracking, visual teaming (depth perception) and visual spatial awareness. She underwent extensive testing which were as follows: Fudus photo interpretation showing normal retinal findings OD and OS with a diagnosis of myopia; sensory motor interpretation for eye teaming problems, visual spatial issues and saccadic eye movement problems which showed convergence insufficiency. She showed positive response or stability of her visual system with the introduction of therapeutic lenses. Dr. diagnosed convergence insufficiency, saccadic dysfunction, binocular vision disorder, visual spatial disorientation, dry eye syndrome, myopia OD, astigmatism OD and OS, presbyopia OD and OS and history of traumatic brain injury. She gave samples of Systane eye drops and educated the patient on subconjunctival hemorrhages. Dr. recommended neurosensory testing for objective measurements and improvements with therapeutic prescription and also continued her on therapeutic lenses with blue tint.

On July 29, 2010, M.D., denied the request for neurosensory testing with the battery of tests for following reason: *“The medical records are incomplete. The medical records do not contain any information related to this patient’s initial head injury or subsequent evaluations, treatment, imaging studies, or subspecialty evaluations. There is a gap of over one year and no prior optometry evaluations, neuro-ophthalmology evaluations, ENT evaluations, or neurology evaluations. There is no information which objectifies or corroborates the claimant’s ongoing symptoms over the last year. This will be important to review prior to embarking upon multiple neurodiagnostic studies one year post injury. There is no information how the results of this extensive testing will affect medical decision making or overall outcome of this case.”*

It was noted that the patient was under the care of a pain management physician Dr. and was first seen in August 2010. Examination showed continued pain, but otherwise non-significant. She was on Fentanyl patches, Flexeril and Tylenol No.3 for breakthrough pain. Her care was apparently going to be transferred to another pain physician. She was also seeing an acupuncturist which helped reduce her pain.

A designated doctor’s exam was completed on December 8, 2010, by M.D., who deferred maximum medical improvement (MMI) and felt she required further testing as requested and could not return to work due to cognitive and visual impairments.

On May 31, 2011, Dr. performed a visual examination which showed deficits in visual tracking, visual teaming (depth perception) and visual spatial awareness.

He diagnosed convergence insufficiency which was severe and worsening, deficiency of saccadic eye movements with reading speed in the 5th percentile, diplopia within central 30 degrees of vision per Red lens test, lack of coordination/visual spatial disorientation, binocular vision disorder with negative recovery on base-out (convergence) ranges, hyperopia OS, nuclear sclerosis OD and OS and visual field deficits OD and OS. Visual field interpretation showed significant magnocellular deficits/peripheral vision defects OD and OS. The patient showed good response with therapeutic lenses. Dr. Lowell once again recommended obtaining neurosensory testing including VEP to assess objective neurological improvement with VEP.

On June 9, 2011, D.O., denied the request for sinusoidal vertical axis rotational testing with the following rationale: *“There was no indication of any particular abnormalities occurring objectively on physical examination that would have justified the need for all the specialized testing being requested...in this case the previous designated doctor examination report indicated the need to do neuropsychological evaluation/testing, but yet neurological examination was normal and there was no mention anywhere the medical necessity to do the multiple tests for the patient’s reported visual deficits associated with any type of traumatic brain injury that would have justified the need for the multiple tests that were done. In this case, for the post-concussion condition, there would be no indication for the multiple studies or workups that were done based on the guidelines criteria. Therefore, the medical necessity was not established for the multiple tests and therefore requests are not medically reasonable or necessary.”*

On June 10, 2011, an appeal for reconsideration of the above request was placed.

On June 13, 2011, M.D., ophthalmologist upheld the non-certification of the request (CPT codes 92546, 92545, 96111, 95930, 92588, 92548) for the following rationale: *“The AP feels strongly that the claimant needs treatment for convergence insufficiency and double vision. She wanted to perform other testing for the claimant’s “ringing in her ears” and dizziness. CPT codes 92545, 92546, 92548, and 92588 are services that fall within the scope of audiology/otolaryngology and are outside the scope of optometric/ophthalmologic practice. CPT 95930 is for visual evoked potential and the optometric records do not support the medical necessity of this service. CPT 96111 is a service that falls within the scope of psychology and not within optometric/ophthalmologic practice. Visagraph service is not listed in the CPT manual for ophthalmologic services and no information regarding the service was found on the American Academy of Ophthalmology.”*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

I HAVE BEEN ASKED TO REVIEW THIS PARTICULAR RECORD WITH RESPECT TO PATIENT’S COMPLAINTS OF DIPLOPIA AND HEADACHES SUBSEQUENT TO A HEAD INJURY AS A RESULT OF HER SLIPPING AT HER PLACE OF WORK IN THE RESTROOM ON A PAPER TOWEL HITTING HER HEAD. HISTORICALLY, THE CLAIMANT HAS MENTIONED SLIPPED AND FELL IN THE RESTROOM AT WORK THEREAFTER COMPLAINING OF NECK AND BACK PAIN AND HEADACHES, POOR CONCENTRATION AS

WELL AS DIFFICULTY WITH PERIPHERAL VISION AS WELL AS DOUBLE VISION. FULLY ONE YEAR LATER THE CLAIMANT WAS SEEN BY O.D., IN JULY OF 2010 FOR ONGOING HEADACHES, BLURRED VISION AND BALANCE PROBLEMS. THE CLAIMANT UNDERWENT EXHAUSTIVE TESTING AND YOU HAVE ASKED ME TO RESPOND TO THE REQUEST FOR FURTHER TESTING WITH RESPECT TO THIS INCIDENT.

MULTIPLE REVIEWERS HAVE EVALUATED THE RECORDS AND THE RECORDS AVAILABLE TO ME AT THE TIME OF THIS REVIEW ARE THE BASIS FOR MY DETERMINATION OF THIS CLAIM. IT IS NOTED DURING THE EVALUATION OF THIS CLAIM THAT EXHAUSTIVE TESTS WERE CARRIED OUT THAT APPEAR TO BE OUTSIDE THE SCOPE OF OPTOMETRY THAT REFERRED TO AUDIOLOGY AND OTOLARYNGOLOGY. FURTHERMORE, IT IS MY OPINION THAT SEVERAL OF THESE TESTS WERE NOT INDICATED. THE VISUAL FIELD THAT WAS PERFORMED USED THE FREQUENCY DOUBLING TECHNIQUE THAT IN MY OPINION IS LESS INFORMATIVE THAN AUTOMATED HUMPHREY VISUAL FIELD EVALUATION. FURTHERMORE, THERE IS NO RECORD OF IMAGING THAT INCLUDES MRI OR CT SCAN OF THE HEAD OR NECK. FURTHERMORE, THERE IS A HISTORY OF PREVIOUS TRAUMA AND FALLS THAT INVOLVED THE NECK, SHOULDERS AND BACK THAT OCCURRED IN 2002 AND 2004. THERE IS A QUESTION AS TO WHETHER THIS COMPLAINT OF DOUBLE VISION, HEADACHES, ECETERA ARE POSSIBLY PRE-EXISTANT. FURTHERMORE, NEUROLOGICAL EXAMINATION WAS NONCONTRIBUTORY AS TO THE BASIS FOR THIS INDIVIDUAL'S COMPLAINTS AND FELT THAT THE EXAM WAS WITHIN NORMAL LIMITS. I HAD SEVERAL CONCERNS WITH RESPECT TO THIS PARTICULAR CLAIM, NUMBER ONE, THE LENGTH OF TIME BETWEEN THE FALL IN XX/XX AND HER FIRST EVALUATION BY AN EYE CARE PROFESSIONAL OVER ONE YEAR LATER DOES GIVE ME SIGNIFICANT PAUSE FOR CONCERN. FURTHERMORE, I DO NOT SEE ANY EVIDENCE OF A NEURO-OPHTHAMOLOGICAL EXAMINATION OR CONSULTATION BY A BOARD CERTIFIED NEURO OPTHAMOLOGIST. I ALSO HAVE CONCERNS AS TO THE POSSIBILITY FOR ORTHOPTIC CONSULTATION FOR THE PATIENT'S APPARENT CONVERSION INSUFFICIENCY WHEREBY PRISM THERAPY OR PRISM ADAPTATION TESTING INCLUDING OCULAR EXERCISES WERE NOT AFFORDED.

MY OVERALL OPINION OF THIS PARTICULAR MATTER IS THAT MULTIPLE TESTS WERE RUN AND REQUESTED THAT "A" WERE NOT INDICATED AND "B" FELL OUTSIDE THE SCOPE OF THIS PROVIDER'S PRACTICE. I THEREFORE UPHOLD THE DENIAL FOR THE DETERMINATION AS PREVIOUSLY HAS BEEN RENDERED AS MEDICAL DOCUMENTATION DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE HEALTHCARE SERVICES IN DISPUTE.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- MEDICAL JUDGEMENT, OVER FORTY YEARS OF CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**